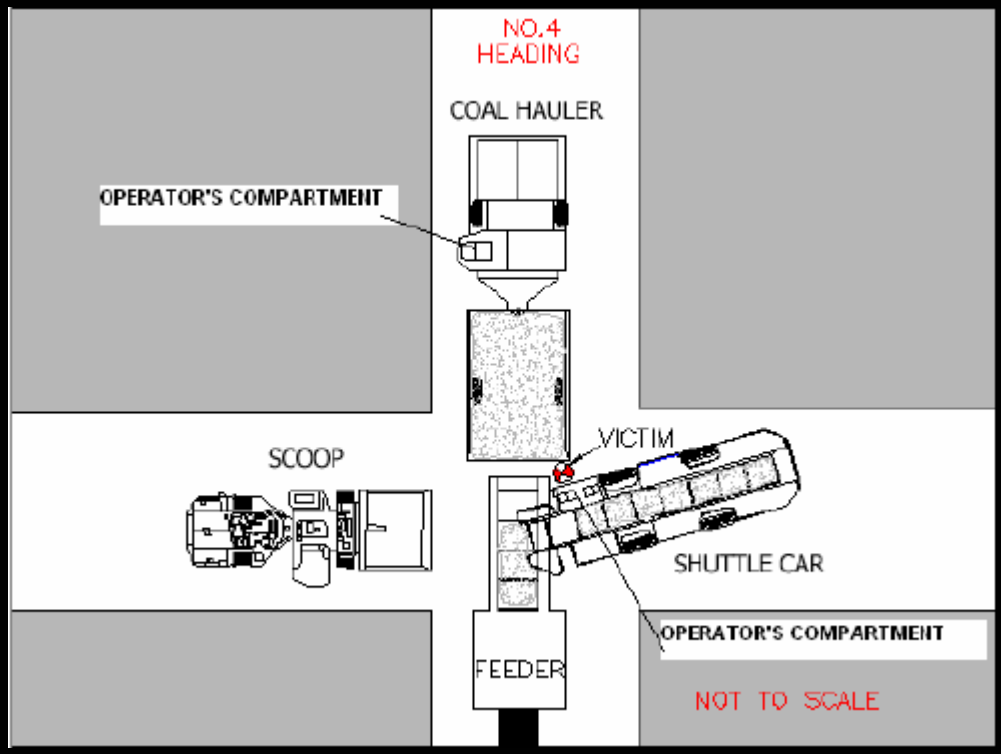
*This presentation is for illustrative and **general** educational purposes only and is not intended to substitute for the official MSHA Investigation Report analysis nor is it intended to provide the sole foundation, if any, for any related enforcement actions.*

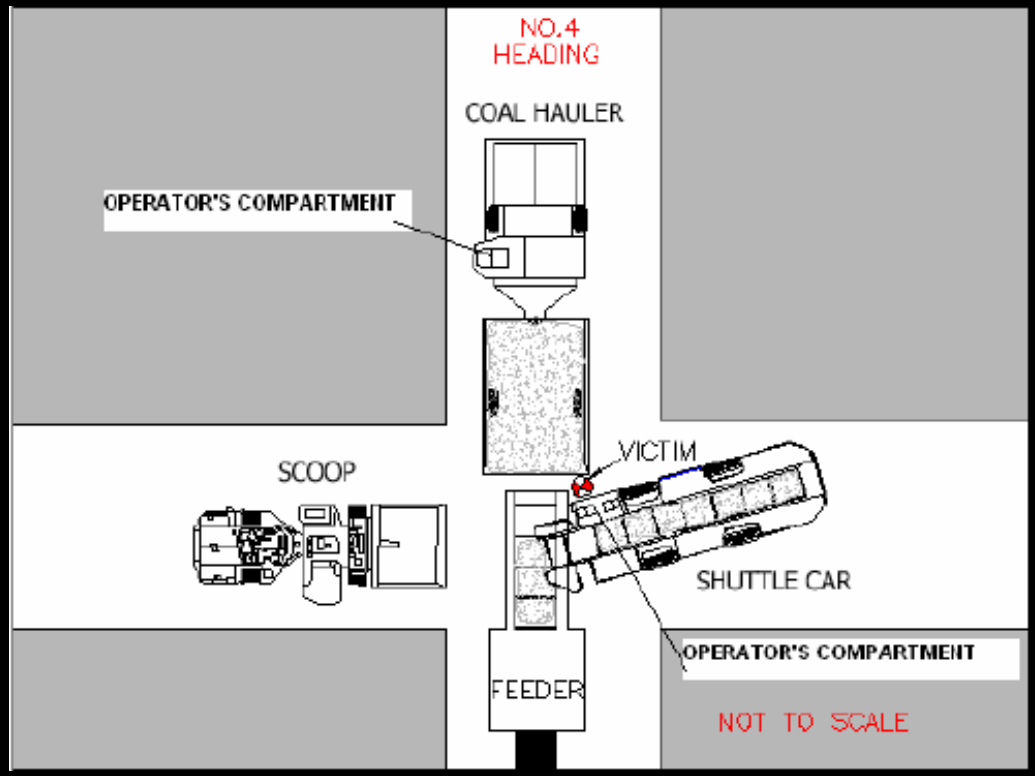
GENERAL INFORMATION

Coal Mine Fatal Accident 2005-22



Operator:	H & D Mining Inc.
Mine:	Mine No. 3
Accident Date:	December 30, 2005
Classification:	Powered Haulage
Location:	Dist. 7, Harlan County, Kentucky
Mine Type:	Underground Coal Mine
Employment:	31
Production:	1,500 Tons/Day

ACCIDENT DESCRIPTION



On December 30, 2005, a 29-year old shuttle car operator with 4 years mining experience, was fatally injured, when he was struck from behind by a loaded Coal Hauler (ramcar type coal haulage vehicle). The victim had exited the shuttle car to use the mine telephone and was reportedly waiting for the belt to be re-energized.

The accident occurred because the available equipment and procedures for operating the coal haulage system did not ensure that mobile equipment operators had clear visibility at the section loading point.

ROOT CAUSE ANALYSIS

Causal Factor: The Coal Hauler was loaded in a manner which resulted in the load obstructing the vision of the operator.

Corrective Action: An action plan was submitted to the District Manager for approval which limits the load being hauled to the height of the haulage units' sideboards. Also, a Notice to Provide Safeguard(s) was issued requiring all coal haulage equipment to be loaded as not to impede visibility of the operator and in no case higher than the manufactures sideboards.

Causal Factor: The interchanging of equipment allowed for the victim's being located in an area that was not visible to the other operator.

Corrective Action: An action plan was submitted to the District Manager which does not allow for incompatible types of haulage equipment to intermix. Also, a Notice to Provide Safeguard(s) was issued requiring that only compatible equipment be used when hauling coal (ie. standard and off standard shuttle cars or two Coal Haulers).

ROOT CAUSE ANALYSIS

Causal Factor: The operator failed to ensure that initial select supervisor training was provided as required by Title 30, Part 75.1713-3.

Corrective Action: The supervisor was trained in accordance with 75.1713-3. A meeting with the operator was conducted to review the requirements of Title 30, Part 75.1713-3 and 75.1713-5.

ENFORCEMENT ACTIONS

Safeguard No. 7553510 was issued to H&D Mining Inc. per 30 CFR 75.1403:

"The Long Airdox Coal Hauler (s/n 818-1077) was loaded above the sideboards impeding the visibility of the operator. A fatal accident occurred when the operator approached a feeder that was occupied with another machine dumping. This is a Notice to Provide Safeguard(s) requiring all coal haulage equipment to be loaded as not to impede visibility of the operator and in no case higher than the manufacturer's sideboards.“

Safeguard No. 7553511 was issued to H&D Mining Inc. per 30 CFR 75.1403:

"The Long Airdox Coal Hauler was working in conjunction with a 10SC Joy shuttle car hauling coal from the miner to a feeder to dump. This compliment of equipment set the stage for a traumatic fatal accident to occur due to the blocked field of vision of the Coal Hauler operator. This is a Notice to Provide Safeguard(s) requiring that end driven haulage equipment shall not be intermixed with other types of face haulage equipment."

ENFORCEMENT ACTIONS, Cont'd.

Citation No. 7553512 was issued to H&D Mining Inc. for a violation of 30 CFR 75.1713-3:

"Initial first-aid training for select supervisor James Couch, foreman, was not conducted. James Couch was the select supervisor on the 001 section of the H&D mine No. 3 when a traumatic injury accident occurred. After interviews with medical personnel it was determined that this injury became a fatality because basic first-aid was not properly performed prior to the injured employee being transported." H&D's failure to conduct the required select supervisor first aid training contributed to the victim not receiving the proper first aid at the mine.

BEST PRACTICES

- Remain in a safe area away from mobile equipment or where equipment operators can readily see you.
- Maintain clear visibility with all personnel in your vicinity when operating mobile equipment.
- Sound warnings when the operator's visibility is obstructed, such as when making tight turns, reversing direction, or approaching curtains.
- Wear reflective clothing to ensure high visibility when necessary to walk or work in the area of moving mobile equipment.
- Exercise caution and signal your presence to mobile equipment operators.